PRINTED: 6/24/2023 FORM APPROVED 2567-L

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 395050		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 05/01/2023			
GARVEY MANOR			1037 SOUTH I	STREET ADDRESS, CITY, STATE, ZIP CODE: 1037 SOUTH LOGAN BOULEVARD HOLLIDAYSBURG, PA 16648					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIEN MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	(X5) COMPLETE DATE			
F 0000  F 0658 SS=D	Based on a complaint secompleted on May 1, 2 Garvey Manor was not following requirements Subpart B, Requirement Facilities and the 28 PA Pennsylvania Long Tet Regulations.	2023, it was determine in compliance with sof 42 CFR Part 483 ats for Long Term CA Code, Commonwerm Care Licensure	ned that the B, are ealth of	F 0658	TITLE.				
LABORATORY I	DIRECTOR'S OR PROVIDER/SUPPLI	ER REPRESENTATIVE'S SIGN.	ATURE		TITLE:	(X6) DATE:			

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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	OF DEFICIENCIES AND RRECTION (POC)	(XI) PROVIDER/SUPPLIER/G IDENTIFICATION NUMBER 395050		A. BLDG: _	(X3) DATE SURV COMPLETED:  00  05/01/2023		/EY
GARVEY	OVIDER OR SUPPLIER:  MANOR  SE NUMBER: 070202		STREET ADDRESS 1037 SOUTH HOLLIDAYS	LOGAN BO	OULEVARD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEI MUST BE PRECEEDED BY FULL REGULATORY OF IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0658	Continued from page 1			F 0658			
SS=D	483.21(b)(3)(i) Services Pro Standards  §483.21(b)(3) Comprehensi The services provided or an outlined by the comprehens (i) Meet professional standa This REQUIREMENT is no	ive Care Plans ranged by the facility, as ive care plan, must- ards of quality.			Resident #2 was assessed by Registered Nurse Supervisor 4/26/23 at 9:15am to ensure abnormalities or changes in condition were noted. A ther screen was completed on 4/2 and Resident #2 remained as two with gait belt for transfer non-ambulatory. The Register Nurse and Licensed Practical that responded to Resident 2 were educated on the night of 4/26/23 of the definition of a the immediate intervention of the immediate intervention of certified and licensed nursing began 5/4/23 to ensure that were aware of the definition and the immediate required assessment by a Registered I following a fall to ensure that deficient practice does not on with any other residents. The education will be completed staff as they are scheduled to Agency orientation on the number of certified and licensed was increased to include an additional eight hours of orientation of orientation of orientation of certified and licensed was increased to include an additional eight hours of orientation of certified and licensed was increased to include an additional eight hours of orientation of the completed staff as they are scheduled to the certified and licensed was increased to include an additional eight hours of orientation of the certified and licensed was increased to include an additional eight hours of orientation of the certified and licensed was increased to include an additional eight hours of orientation of the certified and licensed was increased to include an additional eight hours of orientation of the certified and licensed was increased to include an additional eight hours of orientation of the certified and licensed was increased to include an additional eight hours of orientation of the certified and licensed was increased to include an additional eight hours of orientation or the certified and licensed was increased to include an additional eight hours of orientation or the certified and licensed was increased to include an additional eight hours of orientation or the certified and licensed was increased to include an additio	r on that no rapy 26/23 sist of ers and ered al Nurse 's fall of a fall and equired with all g staff of a fall, Nurse at this ecur is with o work.	Completion Date: 06/01/2023 Status: APPROVED Date: 05/15/2023

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395050		B. WING: _		05/01/2023	
GARVEY	VIDER OR SUPPLIER:  MANOR  E NUMBER: 070202		STREET ADDRESS, 1037 SOUTH I HOLLIDAYS	LOGAN BO	OULEVARD		
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0658	Continued from page 2			F 0658			
SS=D					Registered Nurse staff will be re-educated on how to handle and the importance of assess change in condition. Audits immediate assessment from Registered Nurse will occur falls for four weeks and then falls per month for two month Corrective action will be confoliated.	e falls ing of a with all five ths.	

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 395050		(X2) MULTI A. BLDG: _ B. WING: _		(X3) DATE SURVE COMPLETED: <b>05/01/2023</b>	ΞY
GARVEY	VIDER OR SUPPLIER: MANOR SE NUMBER: 070202	1	STREET ADDRESS, 1037 SOUTH HOLLIDAYS	LOGAN BO	DULEVARD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)			ID PREFIX TAG			(X5) COMPLETE DATE
F 0658 SS=D	Based on review of The Professional and Voca of Nursing, facility polywell as staff interviews facility failed to ensure assessment was comple condition for one of the (Resident 2).  Finding include:  The Pennsylvania Code Vocational Standards, 21.11 (a)(1)(2)(4) indicatives was to collect condition of individuals are norm when determining care and restore the well-beautiful and vocational standards.	tional Standards, Staticies and clinical recis, it was determined to that a registered nure ted with a change in ree residents reviewed by the state Board of Nursicated that the register omplete and ongoing eneeds, analyze the had compare the data ag nursing care needs actions that promote	onal and ing, red data to nealth with the	F 0658			
	The facility's current p	olicy for falls indica	ted that a				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:  A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395050		B. WING:		05/01/2023	
GARVEY	VIDER OR SUPPLIER:  MANOR SE NUMBER: 070202		STREET ADDRESS, 1037 SOUTH I HOLLIDAYS	LOGAN BO	OULEVARD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE	
F 0658	Continued from page 4			F 0658			
SS=D	registered nurse would fall prior to the residen  A comprehensive Mini assessment (a mandate abilities and care needs 5, 2023, revealed that the cognitive impairment, could sometimes under staff for her locomotion diagnoses of demential dated February 16, 202 required two staff to pin wheeled walker for transition of the company of the with Nurse Aide 1 when "going down." The nurse sident to the floor. The from the floor with a full censed practical nurse bed.	mum Data Set (MD d assessment of a rest) for Resident 2, date the resident had seve was sometimes understand, was dependent on and off the unit Resident 2's care possible to the control of the series and the control of the control	sident's red April re erstood, and had lan, resident and a second was different and a second resident resident and a second resident resi				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:  A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395050			<u></u>	05/01/2023	
GARVEY 1	VIDER OR SUPPLIER:  MANOR  JE NUMBER: 070202		STREET ADDRESS, 1037 SOUTH I HOLLIDAYS	LOGAN BO	DULEVARD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH D MUST BE PRECEEDED BY FULL REGULATORY ( IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE
F 0658	Continued from page 5			F 0658			
SS=D							
	Interview with the Director 2023, at 1:50 p.m. condid not assess the residence up off the floor and should have.  28 Pa. Code 211.12(d)	firmed that a register ent prior to the staff I putting her back in	red nurse picking bed and				
F 0689				F 0689			
SS=D							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)  (XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER				PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:		
		395050			<u></u>	05/01/2023	
GARVEY	VIDER OR SUPPLIER:  MANOR  SE NUMBER: 070202		STREET ADDRESS, 1037 SOUTH HOLLIDAYS	LOGAN BO	OULEVARD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENC MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE
F 0689	Continued from page 6			F 0689			
SS=D	483.25(d)(1)(2) Free of Acc Hazards/Supervision/Device §483.25(d) Accidents. The facility must ensure tha §483.25(d)(1) The resident accident hazards as is possil §483.25(d)(2)Each resident and assistance devices to pr This REQUIREMENT is no	t - environment remains as ple; and receives adequate super event accidents.			Resident #2 was assessed by Registered Nurse Supervisor 4/26/23 at 9:15am to ensure abnormalities or changes in condition were noted. A ther screen was completed on 4/2 and Resident #2 remained as two with gait belt for transfer non-ambulatory. Education of certified and licensed nursing began 5/4/23 to ensure that is were aware of the definition and the immediate required assessment by a Registered of following a fall, definition of and consequences of substantiated to ensure that this depractice does not occur with other residents. This education be completed with staff as the scheduled to work. On 4/26/agency Certified Nurse Aide made aware of the facility's was interviewed, and was in that she will no longer be usufacility due to substantiated to prevent this from occurring Changes were implemented orientation of agency nursing	r on that no rapy 26/23 sist of sers and with all g staff staff of a fall, Nurse f neglect stated efficient any on will ney are 23, the e was concern, formed ed in the neglect neg again. with the	Completion Date: 06/01/2023 Status: APPROVED Date: 05/15/2023

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		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:  A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395050			<u></u>	05/01/2023	
GARVEY I	VIDER OR SUPPLIER:  MANOR  E NUMBER: 070202		STREET ADDRESS, 1037 SOUTH HOLLIDAYS	LOGAN BO	OULEVARD		
(X4) ID PREFIX TAG	PREFIX MUST BE PRECEEDED BY FULL REGULATORY O			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0689	Continued from page 7			F 0689			
SS=D					to Garvey Manor. Moving for the education will be given by Staff Development team mer is doing the "office orientation well as the floor staff who is completing the "floor orientation with the agency staff. All curricertified and licensed staff in agency staff will receive re-education of the important following the Activity of Da Living directive and it will be to be presented to all new state orientation to the facility. In addition, agency orientation nursing units for certified and licensed staff was increased include an additional eight horientation. Audits of adhere the Activity of Daily Living will occur with direct care for residents a week for four weet then five residents per month months. Corrective action with completed 6/1/23.	by the other that on" as ation" as ation" arent ocluding oce of a continue of the ocurs of the o	

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 395050		(X2) MULTI A. BLDG: _ B. WING: _		(X3) DATE SURVE COMPLETED: 05/01/2023	EY
GARVEY I	VIDER OR SUPPLIER:  MANOR  E NUMBER: 070202		STREET ADDRESS, 1037 SOUTH HOLLIDAYS	LOGAN BO	OULEVARD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETE DATE	
F 0689 SS=D	Based on a review of costaff interviews, it was failed to ensure that a refollowed for fall prevesthree residents reviewed.  Findings include:  A comprehensive Minical assessment (a mandate abilities and care needs 5, 2023, revealed that the cognitive impairment, could sometimes under staff for her locomotion diagnoses of demential dated February 16, 202 required two staff to piewheeled walker for training note for Resident.	determined that the resident's plan of care ntion and transfers for the detailed (Resident 2).  Immum Data Set (MD) detailed assessment of a resident 2, dather resident had seven was sometimes understand, was dependent on and off the unit. Resident 2's care play, indicated that the two twith a gait belt ansfers.	facility e was or one of  S) sident's red April re erstood, nt on , and had lan, resident and a	F 0689			
	at 6:06 a.m., revealed t	-					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 395050		(X2) MULTIPLE CONSTRUCTION:  A. BLDG:00  B. WING:		(X3) DATE SURVEY COMPLETED: 05/01/2023	
NAME OF PROVIDER OR SUPPLIER: GARVEY MANOR  STATE LICENSE NUMBER: 070202		STREET ADDRESS, 1037 SOUTH I HOLLIDAYSI	LOGAN BO	OULEVARD			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEF MUST BE PRECEEDED BY FULL REGULATORY OR IDENTIFYING INFORMATION)			ID PREFIX TAG	CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
F 0689 SS=D	MUST BE PRECEEDED BY FULL REGULATORY OR LSC		e was d the May 1, 2 was erson es.	F 0689			

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# **Certified End Page**

#### **GARVEY MANOR**

STATE LICENSE NUMBER: 070202 SURVEY EXIT DATE: 05/01/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi

Deputy Secretary for Quality Assurance

fearre Janie

Debra L. Bogu MD

Debra L. Bogen, MD, FAAP Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

### **PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY